

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2011
NAME OF PROVIDER OR SUPPLIER ST VINCENT CARMEL HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 13500 N MERIDIAN ST CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of 1 (one) State hospital complaint investigation.</p> <p>Complaint: #IN00094832 Substantiated; no deficiencies cited related to the allegations.</p> <p>Facility: #003932</p> <p>Date: 12-7-2011</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>St. Vincent Carmel Hospital Inc. is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing services, Indiana State Hospital Licensure Rules.</p> <p>QA: cloughlin 02/13/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1